Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Mountain-Pacific Quality Health

KALISPELL REGIONAL HEALTHCARE

A Novel Approach…

ReSource Teams: Community Collaboration and Caring for High-risk Patients in their Home Settings

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Presentation to Montana DPHHS

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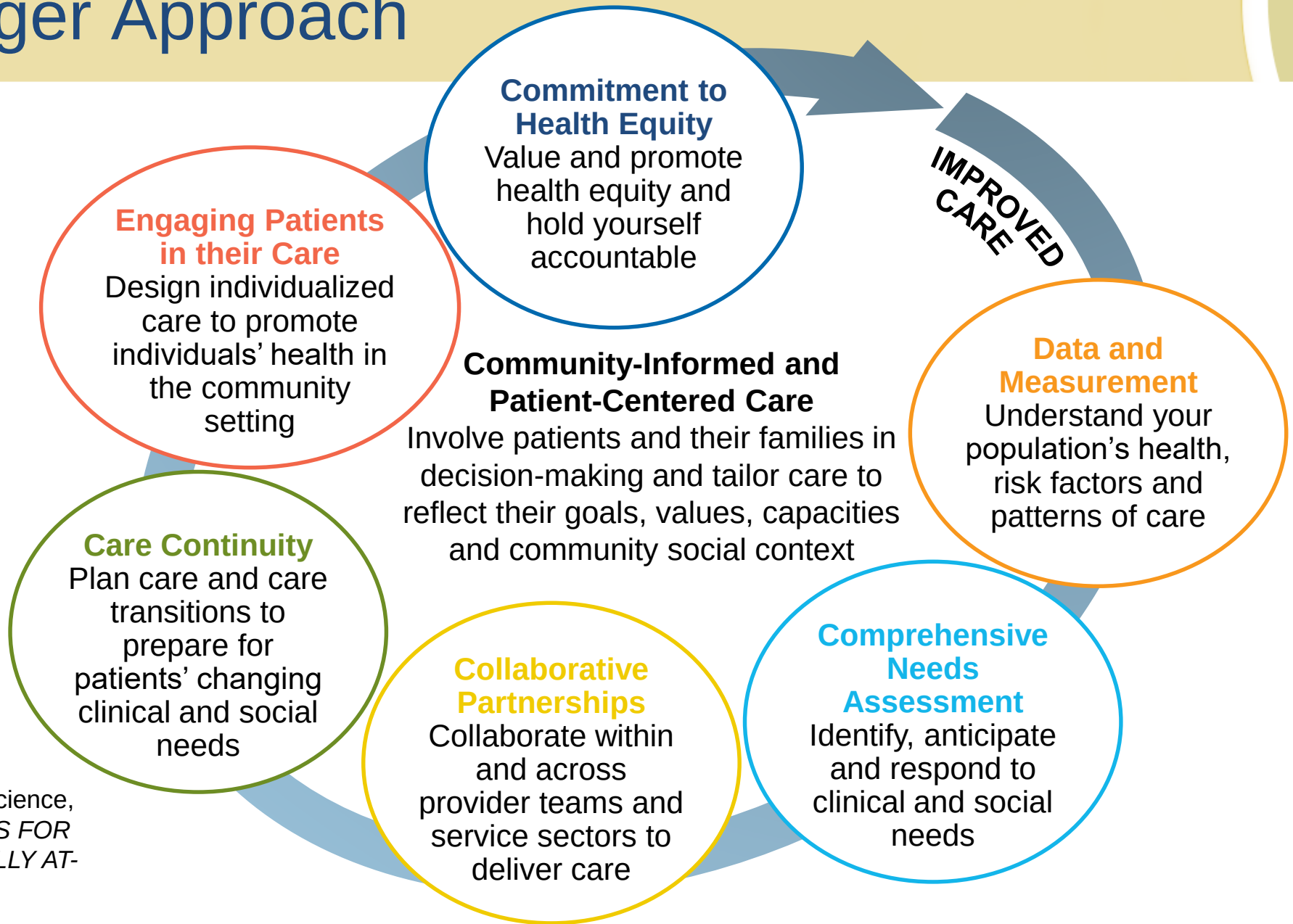
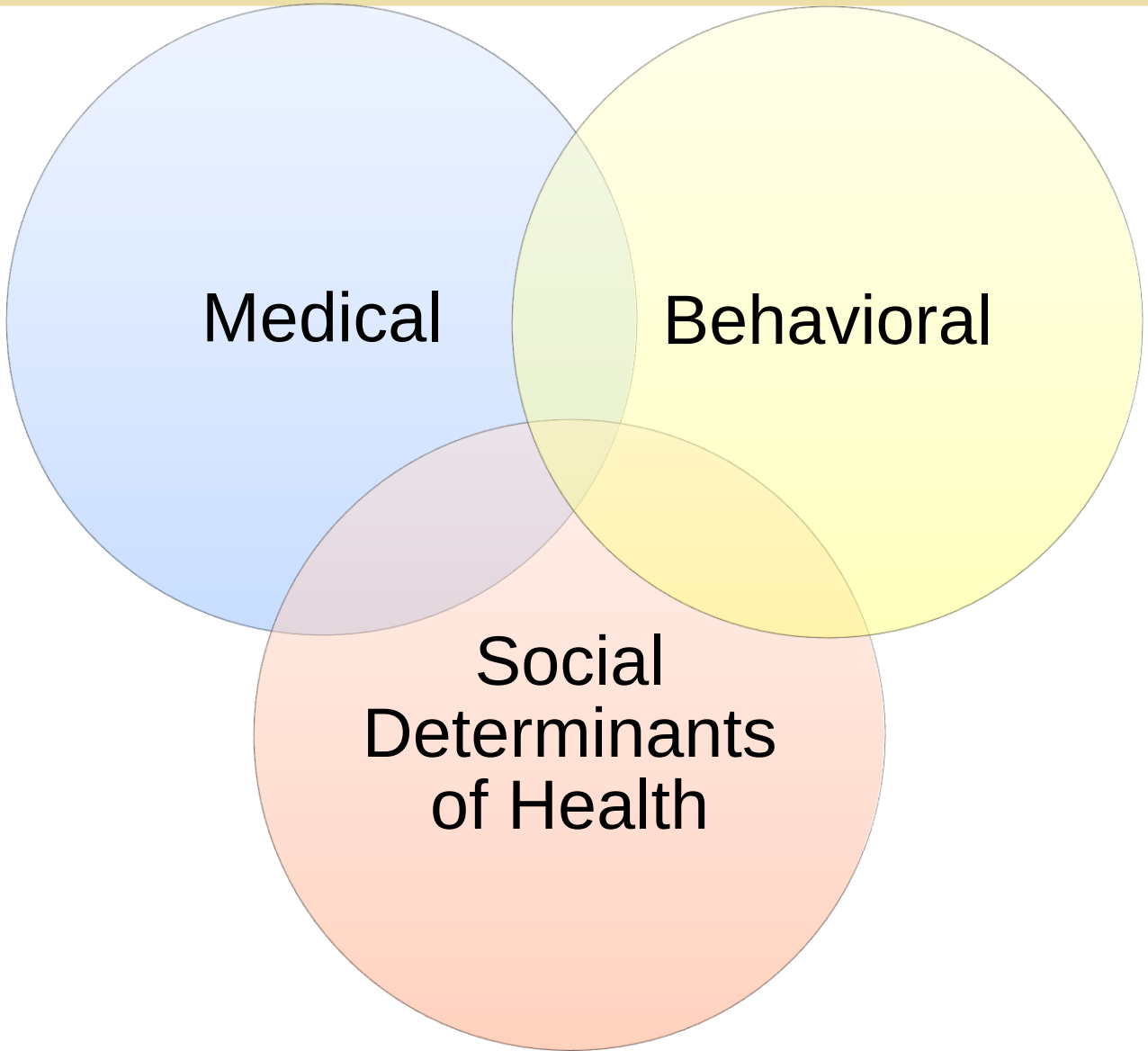
Where Is CMS Going…?
A Larger Approach



Source:
National Academy of Science, *SYSTEMS PRACTICES FOR THE CARE OF SOCIALLY AT-RISK POPULATIONS*

Balancing the Whole Patient



Elements of the Program

Community Readiness: Aligning Key Stakeholders

- QIO-led community coalition
- Local case conferences – Who's problem is it?
- Defining elements of "super-utilizer" and creating a shared vision

Intervention ReSource Teams

- Clinical and nonclinical services wrapped around the patient for 90-day intervention

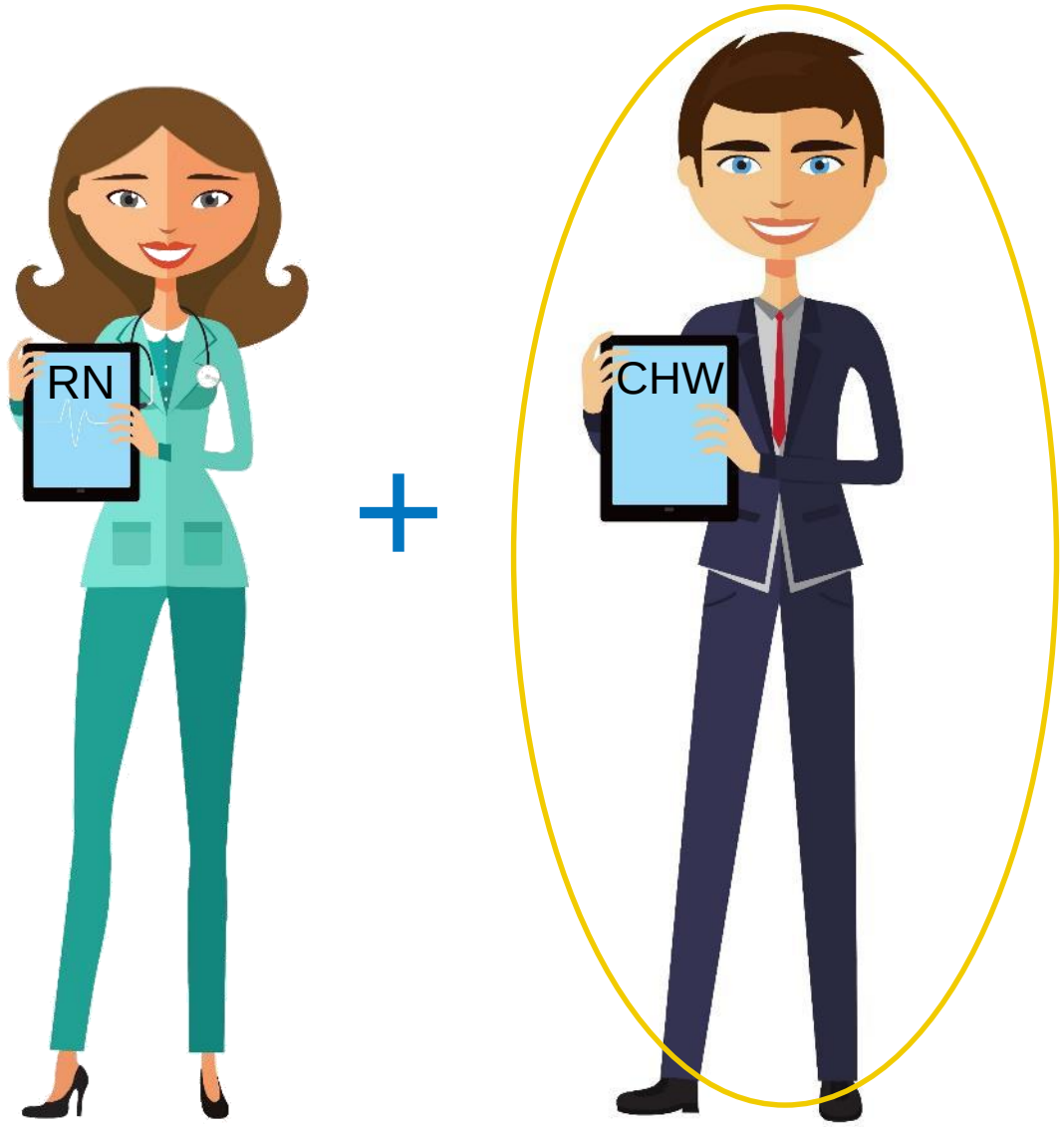
Education and Continuous Improvement

- QIO-led statewide steering committee, including payers, foundations and universities
- Statewide case conferences

QIO = Quality Improvement Organization

The Project: ReSource Teams

- RN + CHW + tablets
- Patients with two or more inpatient admissions and/or emergency department visits in six months
- Patient is not end-of-life
- Social determinants of health
- In-home visits and intensive case management
- Rural location



Community Organizing

Coalition Resources

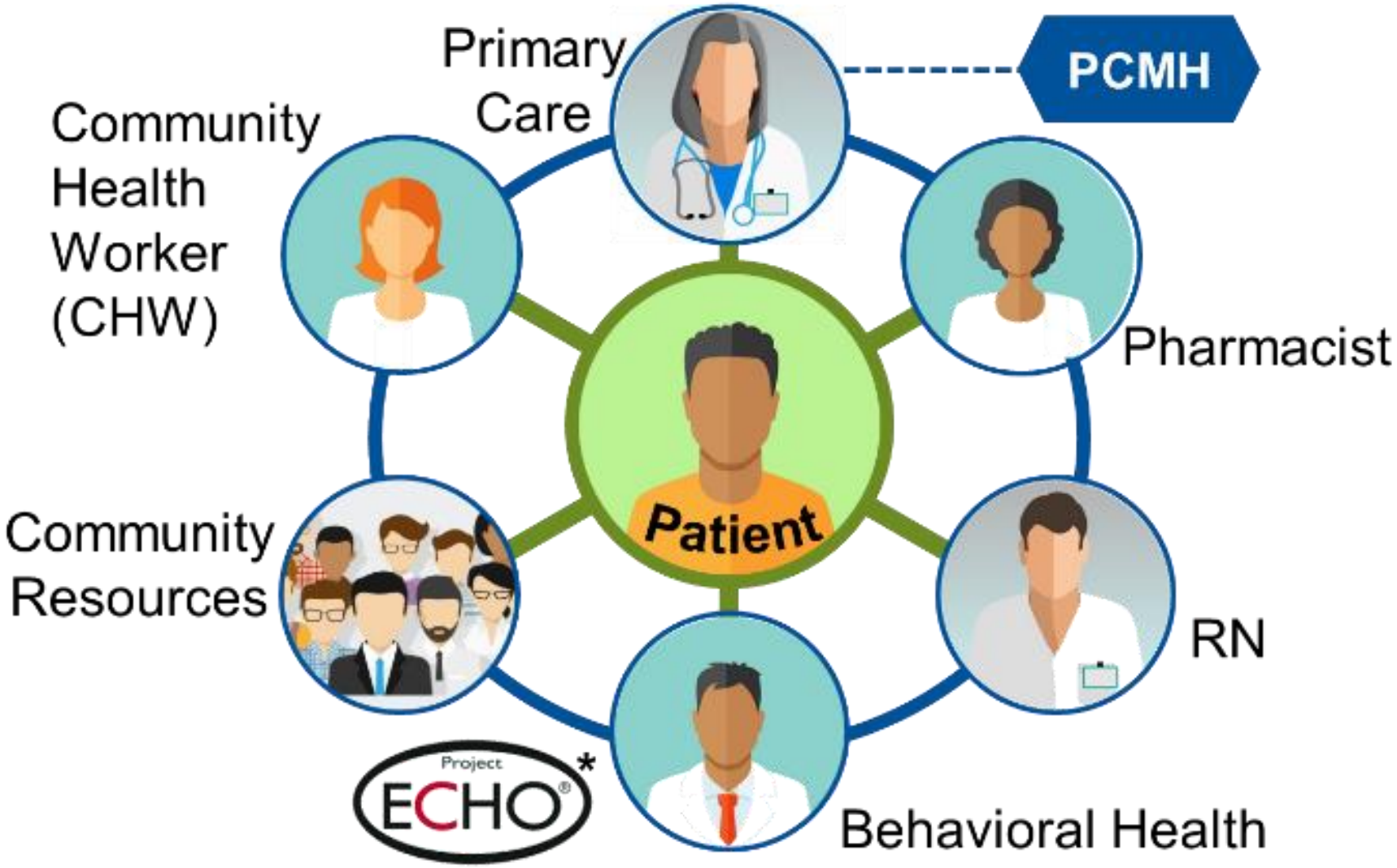
- Health system/ hospital/OP clinics
- FQHC
- Community behavioral health/Sunburst
- LTC
- Transportation
- Housing
- Medicaid

ReSource Teams

Patient

- State DoH
- Gaps in care
- Challenges

Larger Collaborative Model



Super-Utilizer SIP Success
(data thru April 2018)

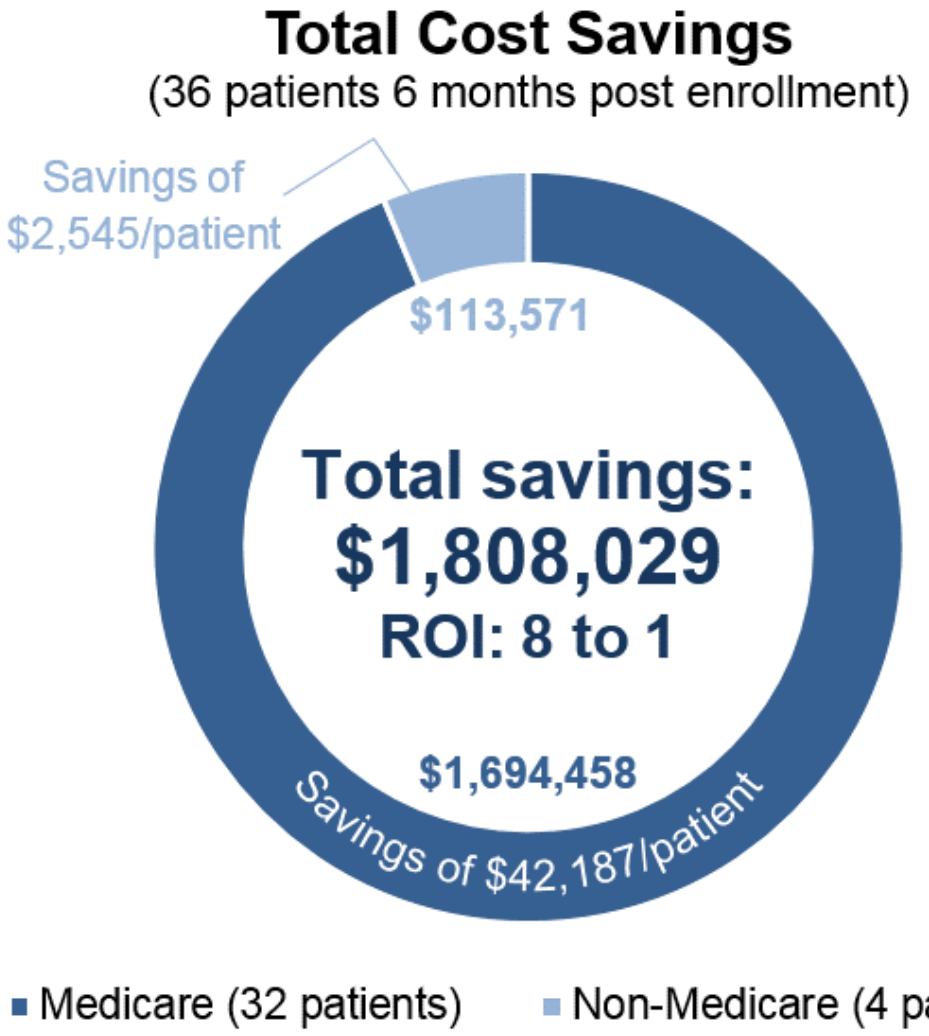
		Billings	Helena	Kalispell	Total
Target # of Patients		50	55	65	**170**
YTD # of Patients	Medicare	9	172*	22	**203**
	Medicare/ Medicaid	12	74*	22	**108**
	Medicare Advantage	3	39*	11	**53**
	Other	14	51*	10	**75**
Current	Total # of Past/Present Patients in Program	31	471*	65	**567**
	# of Handoffs	20	15**	49	**84**

*Patients received phone intervention only

**Helena requires few handoffs due to the care team being clinic case managers

Making the Business Case

- Cost efficiencies through RNs work at the top of their licensure
- CHWs build capacity in workforce
- Movement towards population health and alignment with Advanced Payment Models (APMs)
- Better patient satisfaction
- PCP clinic efficiencies and information
- Decreased utilization of ED and IP readmissions



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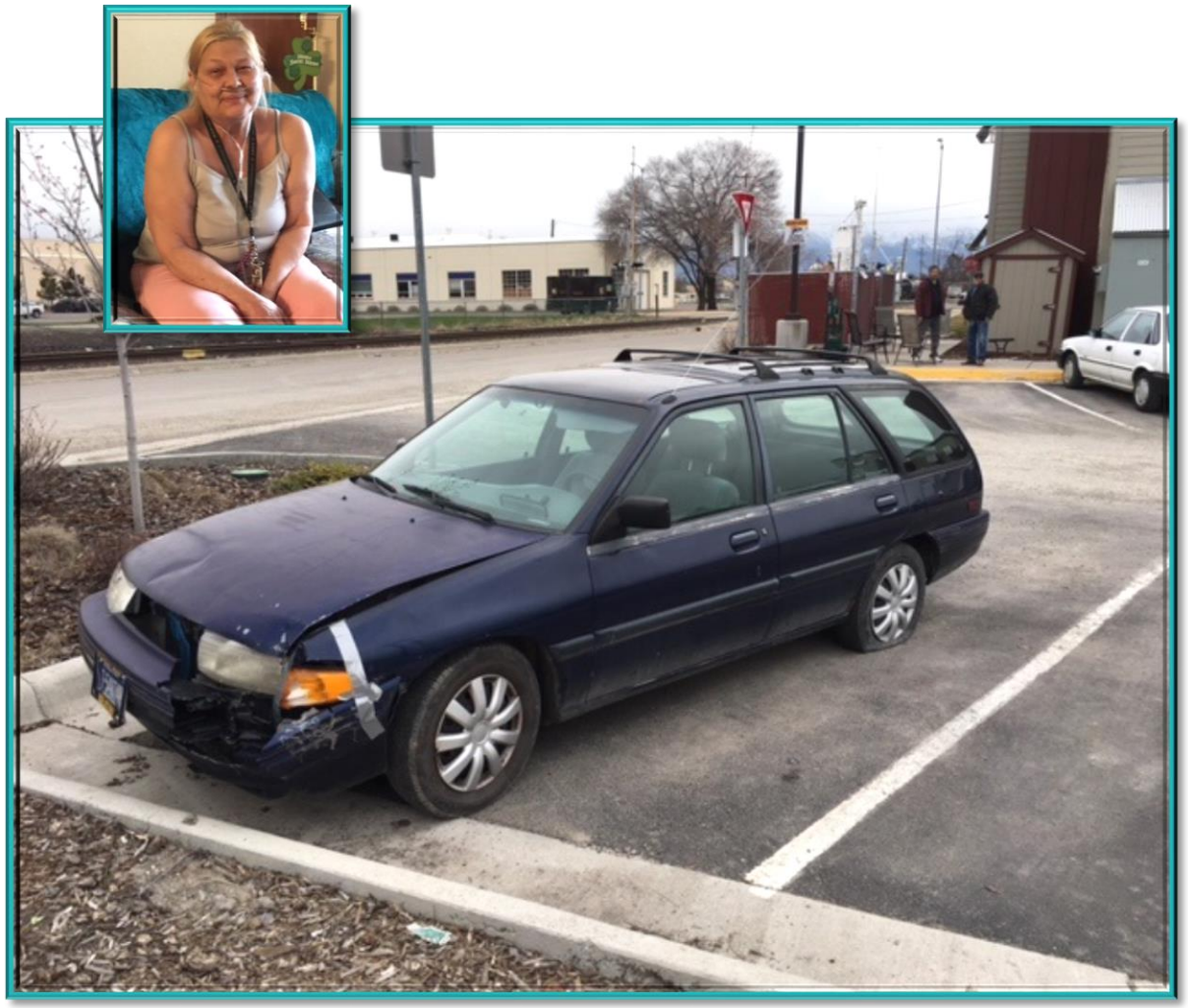
Team Interventions on the Ground:

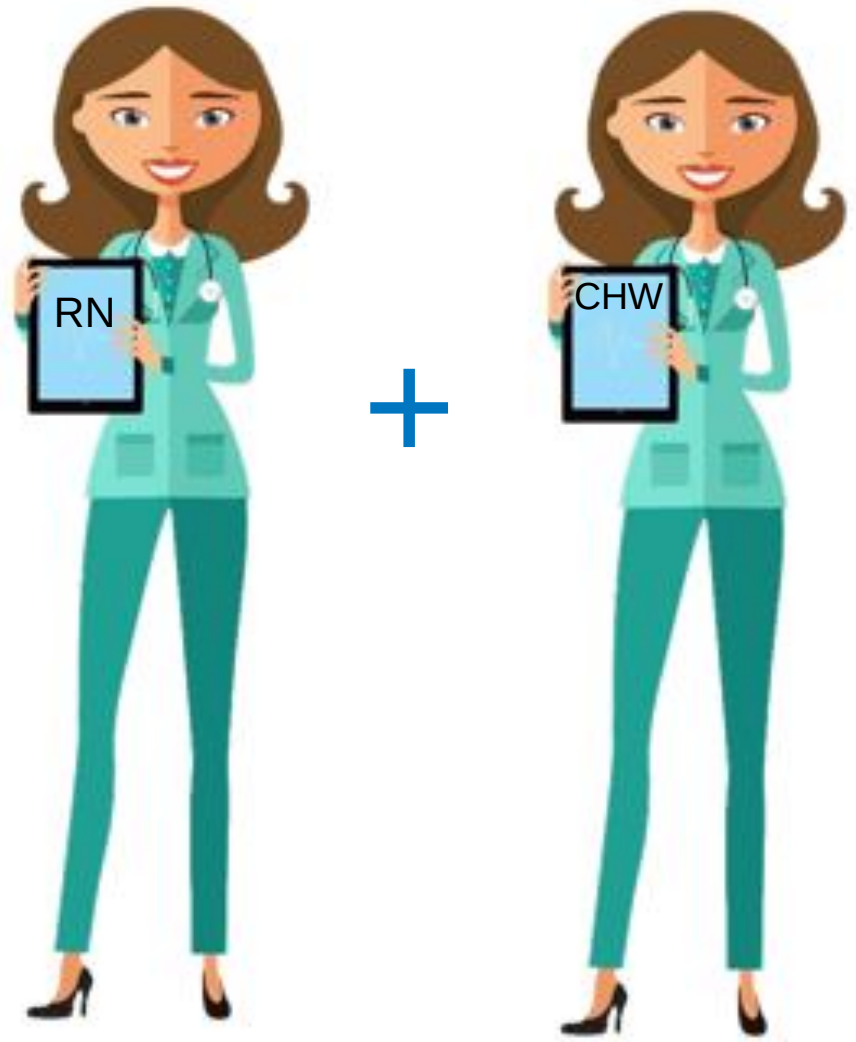
Working with Patients

Simple Demographics
Kalispell (n = 65)

Average Age	Males	Females	Don't Own Their Home	Owned a Car	Active Drivers
					
61	30	35	38 (58%)	50 (77%)	38 (58%)

Complex Care Team





Simple Demographics
Kalispell (n = 65)

CHF Dx	Diabetes Dx	COPD Dx	CKD Dx	ESRD Dx	Cancer Hx	Chronic Pain Dx
28	**25**	**25**	**21**	**6**	**13**	**30**
43.1%	38.5%	38.5%	32.3%	9.2%	20.0%	46.2%

Insomnia Dx	Sleep Apnea	Depression Dx	Anxiety Dx	Other MH Dx	Brain Injury Dx	CVA Hx
17	**22**	**30**	**22**	**15**	**8**	**8**
26.2%	33.8%	46.2%	33.8%	23.1%	12.3%	12.3%

IP MH 12 mos	Antidepressant Rx	Benzo Rx	Opioid Rx	Narcotic Dependency	Methodone Clinic	Marijuana	Caregiver
5	**32**	**17**	**34**	**12**	**3**	**12**	**10**
7.7%	49.2%	26.2%	52.3%	18.5%	4.6%	18.5%	15.4%

Social Determinants of Health (SDoH)

Kalispell ReSource Team Patients ICD-10 Codes to Identify SDoH [n=65]	# of Patients with SDoH	% of Patients with SDoH
Problems related to education and literacy, unspecified	51	78.5%
Problems related to housing and economic circumstances	40	61.5%
Lack of adequate food and safe drinking water	21	32.3%
Insufficient social insurance and welfare support	7	10.8%
Problem related to housing and economic circumstances, unspecified	23	35.4%
Problems related to social environment	39	60.0%
Problems of adjustment to life-cycle transitions	24	36.9%
Problems related to living alone	17	26.2%
Other problems related to primary support group, including family circumstances	37	56.9%
Other stressful life events affecting family and household	23	35.4%
Problem related to primary support group, unspecified	27	41.5%
Problem related to unspecified psychosocial circumstances	51	78.5%

Complex Care
Team-to-Patient Ratio

1 RN 1 CHW iPads	1 RN 2 CHWs iPads	2 RNs 2 CHWs iPads
25	50	100

Complex Care Patients

Pharmacy and Tele-visits

Pharmacy and behavioral health important partners

Pharmacy intervention needed for:

- Medication reconciliation
- Medication education
- Finding alternative low cost meds
- Answering patient questions

Help with narcotic intervention and pain

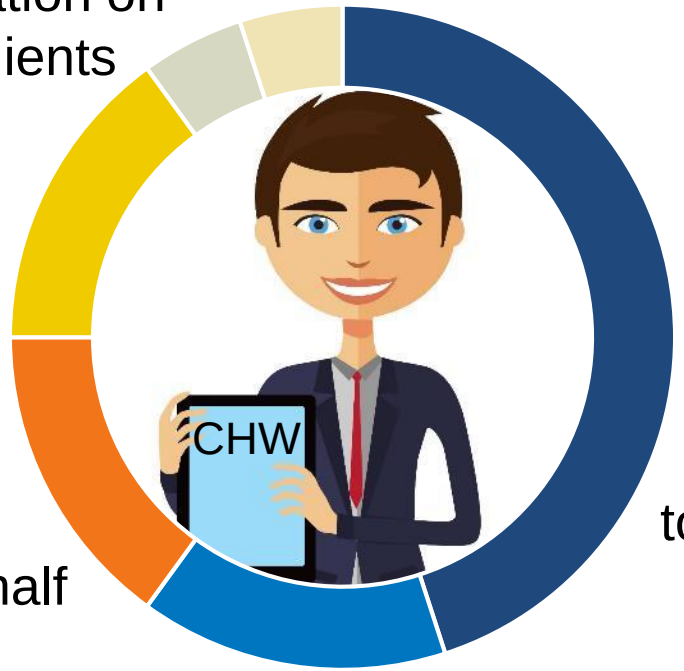
	Billings n=31	Kalispell n=65
Opioids	18	34
Benzodiazepines	6	17
Narcotic dependency ICD-10 F11.02	16	12
	51.6%	18.5%

CHWs Duties

5%
documenting information on the clients

5%
building and updating a care plan

10-20%
visiting and working with the client

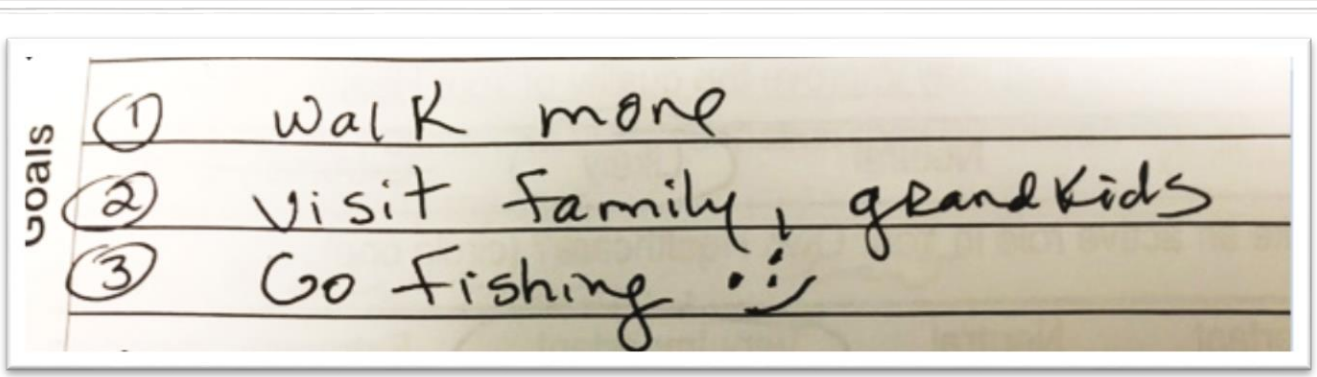


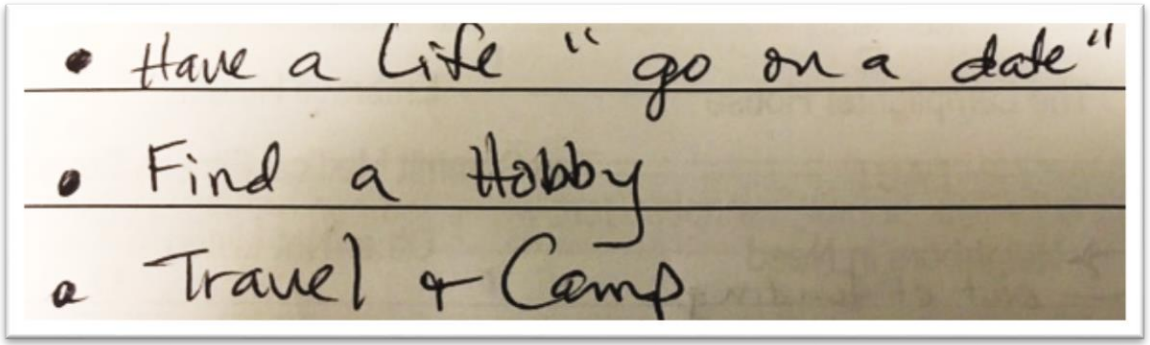
40-50%
filling out applications for various community resources and bringing together required paperwork

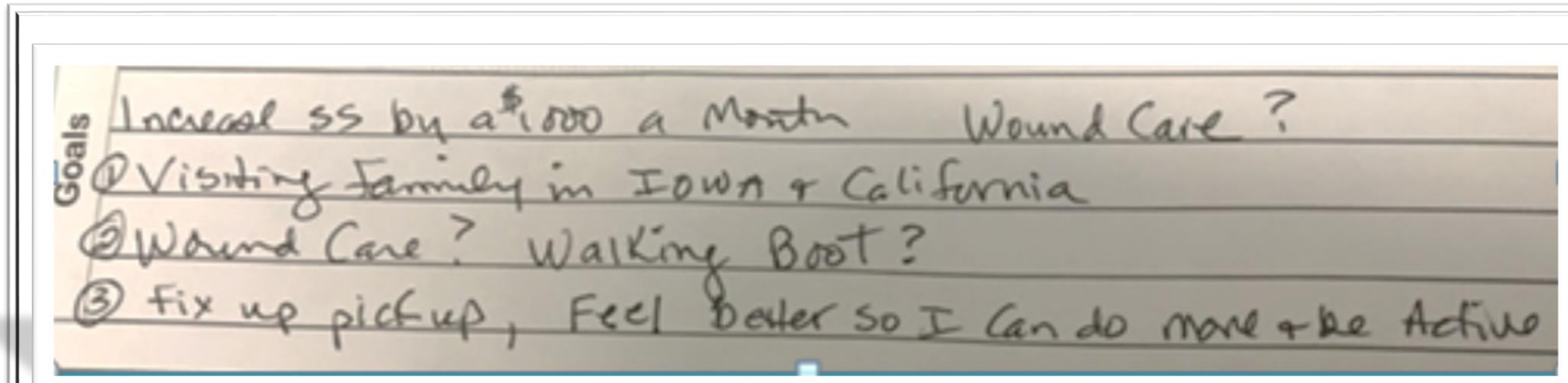
15%
leg work on behalf of the client

15%
networking and coordinating with resources in the community

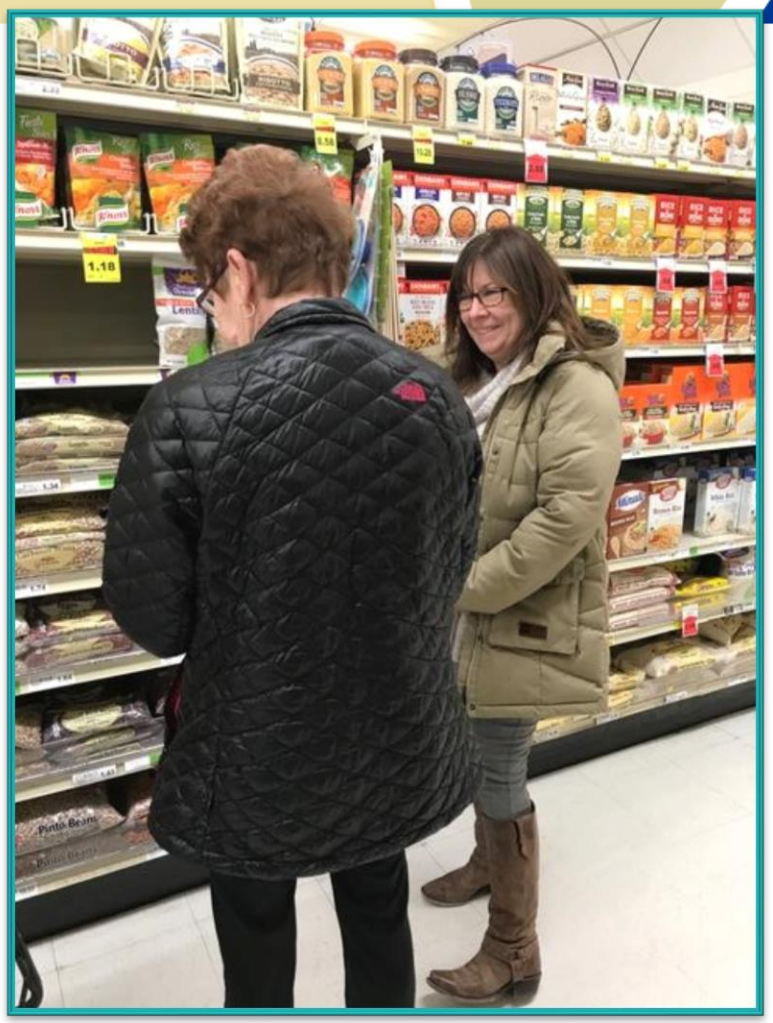
Patient Goals:
Individual Driven not Agenda Driven





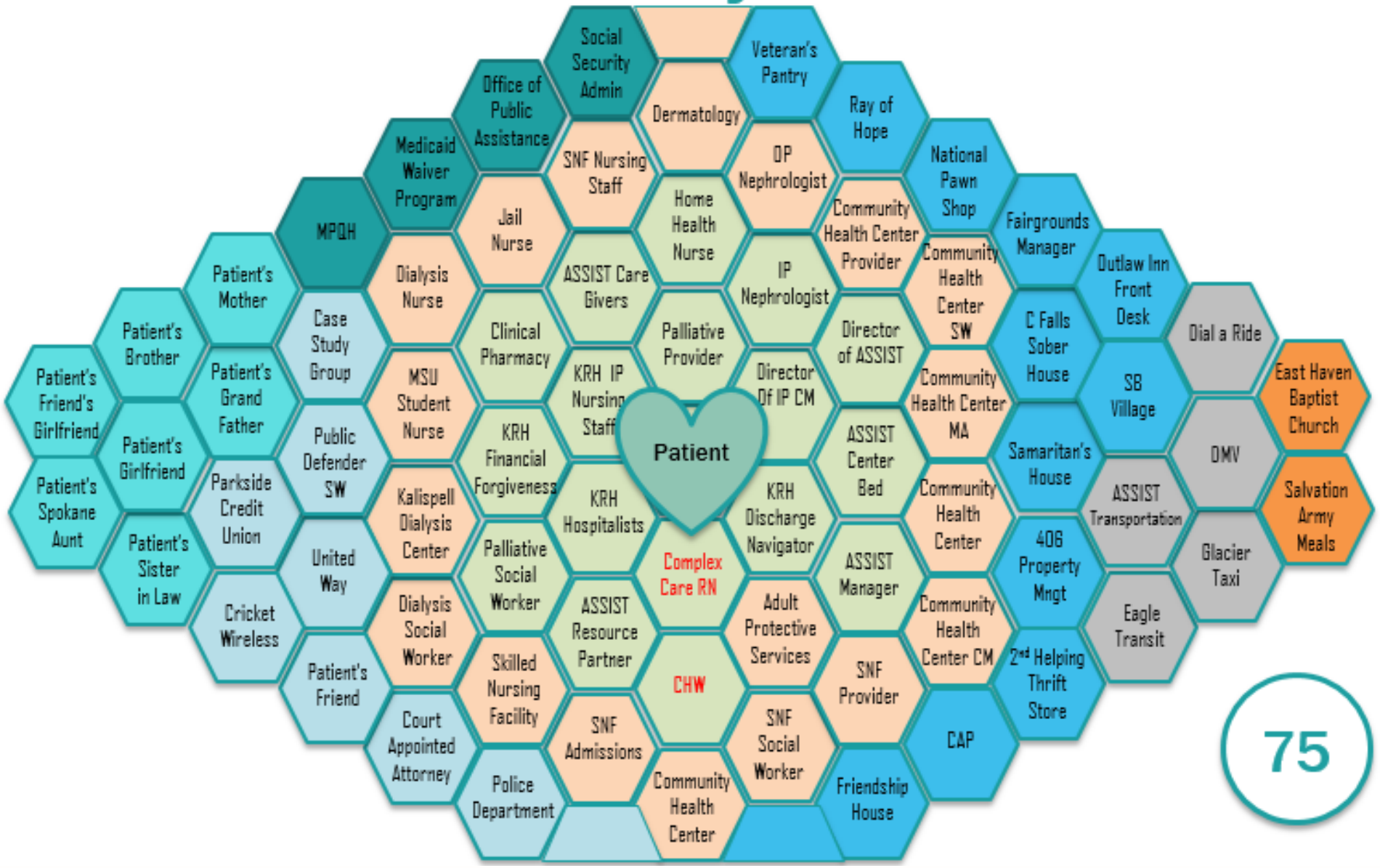


Patient-Centered

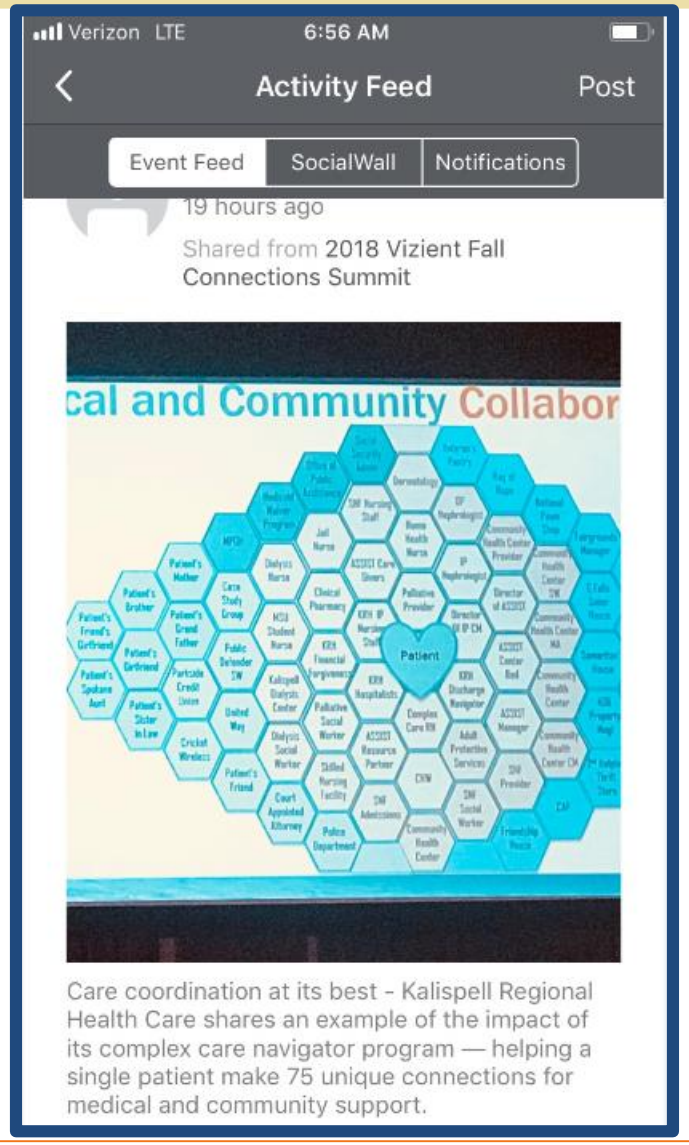


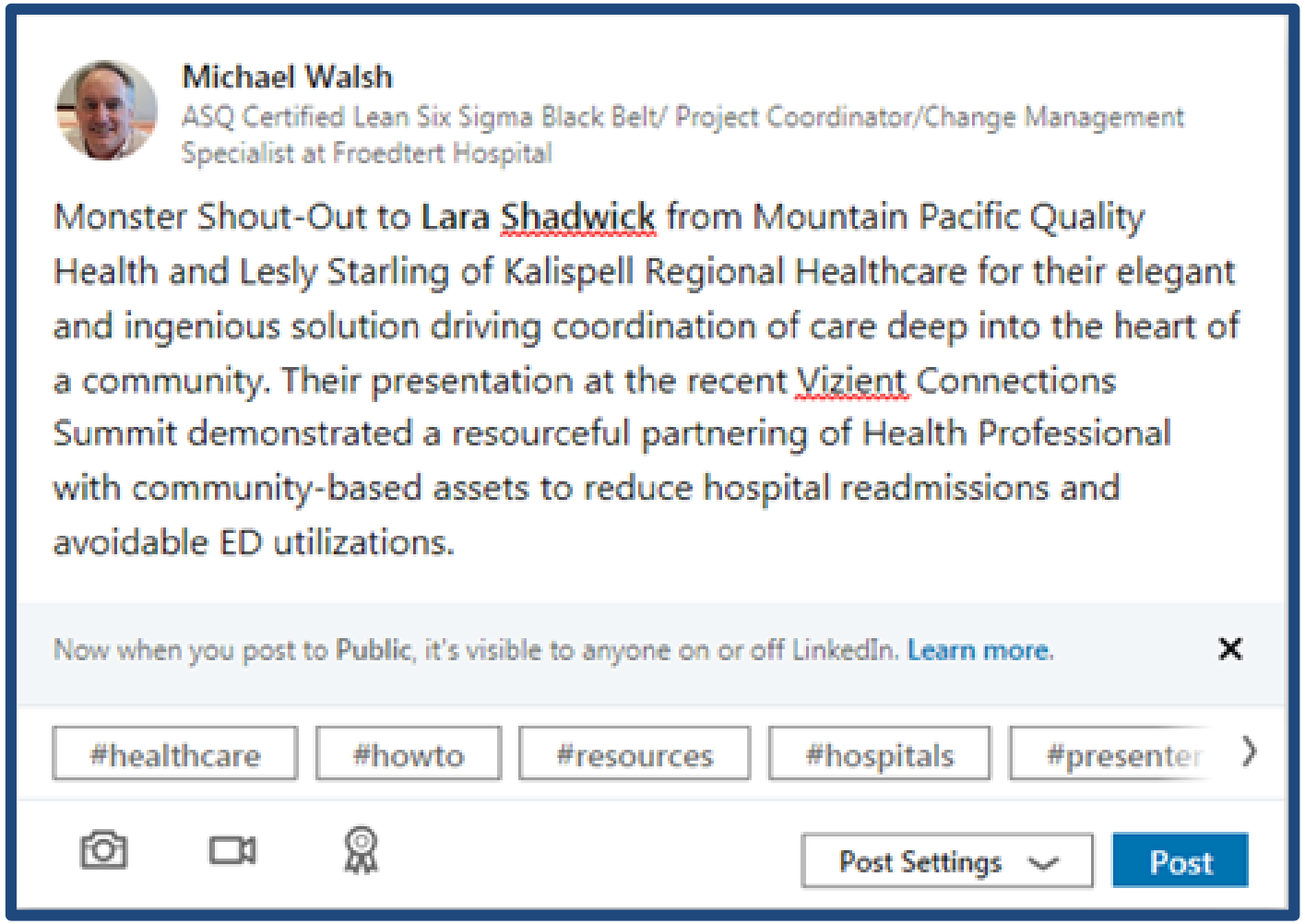
Medical and Community Collaboration

- Inpatient Medical Collaboration
- Outpatient Medical Collaboration
- Housing
- Transportation
- Food Scarcity
- Social Isolation and Family Estrangement
- Community Resources
- Social Services



Presenting Nationally…





In Summary

- Earliest innovators and model builders in Montana (since 12/2014)
  - Data on more than 550 patients
  - Translates across communities (Kalispell, Billings, Helena)
  - Speaking nationally on the model
- Community organizing and feedback loops
  - Community coalitions
  - Case conferences
- Patient-led goals/motivation
- Telehealth – Bringing in additional disciplines:
  - Pharmacy – Medication consults
  - Primary care and specialty navigation
    - Behavioral health integration
  - Nutrition
- Medical/social model – Deals with medically complex AND behavioral health/SUD
- Reach across the silos

Questions or Comments:

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